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BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **TIRA RENE PALFINI[1], P.A.** P.O. Box 283 Tahoe Vista, CA 96148 Physician Assistant License No. PA 22290, Respondent.	Case No. 950-2014-000336 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Maureen L. Forsyth (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs.

2. On or about May 30, 2012, the Physician Assistant Board issued Physician Assistant License No. PA 22290 to Tira Rene Palfini, P.A. (Respondent). The Physician Assistant License

[1] At the time of the events alleged in this Accusation, Respondent's name was Tira Rene Wickland. She has since changed it to Palfini.

was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2018, unless renewed.

JURISDICTION

3. This Accusation is brought before the Physician Assistant Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code), unless otherwise indicated.

4. Section 3527 of the Code provides that the board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license for unprofessional conduct.

5. Section 2234 of the Code states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct that would have warranted the denial of a certificate."

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6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. At all times alleged herein, Section 3502[2] of the Code stated:

"(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant.

"(b) Notwithstanding any other provision of law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient specific orders from the supervising physician and surgeon.

"The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

"(c)

(1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may

[2] Business and Professions Code section 3502 was amended by Stats. 2015, Ch. 536, Sec. 2. Effective January 1, 2016

be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

"(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

"(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow up care.

"(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

"(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

"(2) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

"(3) Notwithstanding any other provision of law, the Medical Board of California or board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

"(d) No medical services may be performed under this chapter in any of the following areas:

"(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

"(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

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"(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

"(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

"(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501."

8. At all times alleged herein, Section 3502.1 of the Code stated[3]:

"(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

[3] Business and Professions Code section 3502.1 was amended by Stats. 2015, Ch. 536, Sec. 3. Effective January 1, 2016.

"(b) "Drug order," for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to " prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

"(2) A physician assistant may not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's

use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with the provisions of Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

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"(g) The board shall consult with the Medical Board of California and report during its sunset review required by Division 1.2 (commencing with Section 473) the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient."

9. At all times alleged herein, California Code of Regulations, title 16, section 1399.521 stated:

"In addition to the grounds set forth in section 3527, subdivision (a), of the Code, the committee may deny, issue subject to terms and conditions, suspend, revoke, or place on probation a physician assistant for the following causes: (a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon. (b) Using fraud or deception in passing an examination administered or approved by the committee. (c) Practicing as a physician assistant under a physician who has been prohibited by the division or the Osteopathic Medical Board of California from supervising physician assistants. (d) Performing medical tasks which exceed the scope of practice of a physician assistant as prescribed in these regulations."

10. At all times alleged herein, California Code of Regulations, title 16, section 1399.540 stated:

"(a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

"(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

"(c) The committee or division or their representative may require proof or demonstration of competence from any physician assistant for any tasks, procedures or management he or she is performing.

"(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician.

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTS

12. Beginning in or around 2012, Respondent worked as Physician Assistant under the supervision of Jay A. Hendrickson, M.D. (Dr. Hendrickson), and B.K.H., M.D., at a pain management practice with multiple locations in Northern California called Hendrickson & Hunt Pain Management Physicians, ("H&H"). On or about July 23, 2012, she took over the care of B.B., a 70-year old woman who had been seen constantly at H&H since she established in 2001.[4]

13. B.B.'s medical record from H&H contains an initial history and physical by Dr. Hendrickson, dated on or about August 24, 2001, indicating that B.B. was then a 59-year old woman referred to H&H for pain management with a chief complaint of low back pain. She rated her pain as 6/10. It indicated she had previously undergone a series of steroid injections and a laminectomy for back pain. It lists a medical history of hypertension, ulcers and cataracts. B.B. reported that she smokes a half a pack of cigarettes per day and has smoked for 25 years. Radiological tests showed bulging discs at multiple points of the spine and some degenerative

[4] Facts alleged outside of the statute of limitations are for informational purposes.

changes and stenosis. She was diagnosed with degenerative disc disease. The treatment recommendation was to increase use of Oxycontin to 80 mg three times per day, to discontinue Vioxx, and to continue with aqua therapy and epidural steroid injections. She was scheduled to be seen again in 8 weeks.

14. B.B.'s records show that she had monthly appointments at H&H up through the date Respondent took over her care in or about July of 2012, with many significant medical events over the years. For the first several months of her care with H&H, B.B. seen primarily by Dr. Hendrickson who increased her Oxycontin use from 320 mg per day to 640 mg per day within the first six months of treatment. He also initiated a short acting opioid for breakthrough pain in B.B., and added a muscle relaxant. After the first few months of treatment, B.B. mostly saw mid-level practitioners under the supervision of Drs. Hendrickson and B.K.H. Dr. B.K.H. provided a series of physical medicine interventions such as nerve blocks and spinal injections, which rarely seemed to provide any significant or lasting pain relief. Over the years, short acting opioids alternated back and forth, usually between Percocet and Norco, and the relaxants alternated back and forth between Baclofen and Soma. Throughout her time at H&H, providers attempted to put B.B. on a medication to treat neuropathic pain, but she regularly stopped these medications herself each time they were tried, complaining of side effects. B.B.'s pain consistently increased after the first few years of treatment. B.B. had her first surgical intervention at U.C. Davis in or around 2002, and thereafter underwent a variety of surgeries and procedures which occasionally seemed to provide some relief, so that she was sometimes reporting pain levels below 5/10. But after in or around 2005 she rarely reported a pain score below 8/10, and by 2010, she almost always reported her pain to be 9/10 or 10/10. B.B. had an intrathecal pump and a spinal stimulator implanted, neither of which B.B. felt improved her condition.

15. For the vast majority of her time at H&H, B.B. was on Oxycontin, usually 640 mg per day. A few times during her years with H&H, B.B. attempted to reduce the Oxycontin and she actually seemed to be off of it entirely for a few months in or around the Spring of 2004. She attempted again in or about July of 2006, this time replacing the Oxycontin with Methadone, but only lasted a week or two before returning to Oxycontin. In or around March of 2007, the

provider attempted a "drug holiday" by replacing the Oxycontin with Opana and then Kadian. B.B. returned to the Oxycontin within the month.

16. When B.B. began her care at H&H, she was diagnosed with degenerative disc disease, and a few years later a diagnosis of myofascial pain syndrome was added. During 2005 the diagnosis of myofascial pain syndrome was removed from B.B.'s record, and a new diagnosis of post laminectomy syndrome replaced it. In or around 2005, providers at H&H raised the issue of psychological counseling with B.B., but she was resistant to the idea. Anti-depressants were prescribed to her, although there are indications that she was not compliant with the instructions on these medications.

17. Indications that B.B. was not taking her controlled medications as prescribed began to appear in the medical record in 2007. On or around April 18, 2007 there is a note in B.B.'s record stating that a previous toxicology report showed the absence of any illicit drugs, but also that none of controlled the drugs B.B. was prescribed were detected either. The note stated that B.B. would have to repeat the toxicology test. At the next appointment, there was no record of a retest or that the issue was raised with B.B. B.B.'s medical records regularly contained template language stating that her current medical regimen had allowed the patient to increase her overall daily function, and that without the current medical regimen the patient would not be able to continue with his or her current activity level. There is also a template paragraph stating that the benefits and risks of opioid/prescribed medication, including death, have been explained to the patient who has a full understanding of the medications prescribed and agrees to proceed with medical management, with all questions answered.

18. On or about June 18, 2008, B.B. saw a nurse practitioner and reported having a trial of a Spinal Cord Stimulator with a provider in San Francisco. She reported her pain level was 10/10 and received refills. On or about June 20, 2008, B.B.'s toxicology test was positive for morphine and hydromorphone, although no provider at H&H had prescribed morphine. On or about July 15, 2008, B.B. called into H&H to ask for an earlier appointment because she was going out of state to visit a sick brother. Dr. Hendrickson provided a 30 day prescription for

Oxycontin. The Medical Assistant who answered the call asked B.B. about the positive morphine result. B.B. stated that her physician in San Francisco gave her a morphine injection when placing leads on the spinal cord stimulator. The Medical Assistant noted that she would inform Dr. Hendrickson.

19. B.B. saw Dr. Hendrickson on or about October 14, 2008, reporting pain at 8-9/10. He continued refills of Oxycontin and Norco. In or about November of 2008, B.B saw Dr. B.K.H., who provided the refills of Norco and Oxycontin. In or around December of 2008, B.B. had high blood pressure, which was not addressed and received refills. She had another refill appointment on or about January 6, 2009. A January 9, 2009 toxicology result showed B.B. was positive for oxymorphone and oxycodone, but negative for hydrocodone, despite being prescribed Norco. On February 3, 2009 B.B. saw a Physician Assistant, reporting 10/10 pain level and received refills on Norco and Oxycontin. There was no reference to the toxicology report in this chart note, which Dr. Hendrickson co-signed on or about February 2, 2009. Chart notes were similar and co-signed by him in March, and April.

20. On or about May 28, 2009, a provider refilled Norco, Oxycontin and Motrin. The provider noted that the Baclofen was not helping B.B.'s muscle spasms. The provider ordered a random toxicology screening. A June 12, 2009 toxicology report showed that B.B. was positive for hydrocodone, hydromorphone, oxycodone and oxymorphone. The record indicated a need to follow up with B.B. at her next appointment. But at B.B.'s next appointment on June 25, 2009, there was no reference to the toxicology report. B.B. reported pain at 9/10 and medications were refilled. The July 23, 2009 appointment record was similar. At the July appointment, B.B. reported starting physical therapy. Although there is no reference to it in the treatment plan, Soma starts to appear on her list of medications at 250 mg four times per day beginning at this date.

21. On or about August 20, 2009, B.B. reported her pain at 8/10 and Norco, Soma and Oxycontin were refilled. It is noted that B.B. was also seeing a chiropractor.

On or around September 18, 2009, B.B. reported 8/10 pain. She stated that she is improving and doing physical therapy exercises. A Physician Assistant noted that she stopped the Soma and is trying to decrease the Oxycontin to 6 tablets per day. On or around October 16, 2009, B.B.

reported 8/10 pain and stated she thinks physical therapy is helpful. B.B. reported that the Oxycontin is controlling her pain. The provider ordered a toxicology screening. The Toxicology report was negative for Soma metabolites, but positive for oxycodone. On or about November 13, 2009, the Physician Assistant noted that the toxicology screening was within normal limits. He refilled Norco, Oxycontin and Soma. Neurontin was added. On or about December 11, 2009, the medications were refilled except that Neurontin was stopped. Exercise was encouraged. On or about January 8, 2010, B.B. reported pain at 9/10, and indicated that she was hospitalized for week for treatment of kidney stones. The Oxycontin was refilled. On or about February 3, 2010, Norco, Oxycontin, Soma, Neurontin, and Motrin were refilled. On or about March 2, 2010, a toxicology screening was ordered. The March 16, 2010, toxicology result was positive for morphine. On or about April 6, 2010, there was no documentation of positive morphine result.

22. B.B. was seen by Dr. Hendrickson on or about May 11, 2010. He refilled Oxycontin, Norco and Soma. He did not document any reference to the toxicology report. In or around June and July, B.B. returned and received refills. She was seen on August 11, 2010, at which she received refills of Norco, Soma and Oxycontin. An August 20, 2010 toxicology report showed that B.B. was positive for metabolites of Soma and Oxycontin, but negative for hydrocodone, despite being prescribed Norco and was again positive for morphine. The chart noted only that B.B. takes Norco as needed.

23. On or about September 9, 2010 Dr. Hendrickson saw B.B., who reported 9/10 pain, and he refilled the Oxycontin. He did not document any reference to the positive morphine result. The paragraphs referencing increasing function and informing patient of risks of medications are included. During the fall of 2010, B.B. was seen monthly for refill appointments, receiving Norco, Soma, and Oxycontin. She had been reporting and continued to report in October that the medications were causing her constipation. In or around December 2010, the provider ordered a toxicology screening be done.

24. On or about December 23, 2010, there is a note in the chart indicating that B.B.'s toxicology result was again positive for morphine, but that B.B. denied taking morphine. The

note stated "A PAR has been ordered for this patient. Patient's PAR report was uneventful and through research with the lab this appears to be a false negative." On or about January 12, 2011, B.B. was seen by a Physician Assistant who refilled the Oxycontin and ordered another toxicology screening.

25. On or around January 27, 2011, the toxicology report again showed positive for morphine. On or about February 14, 2011, Dr. B.K.H. saw B.B., who reported 8/10 pain. The note states "Patient has positive MS on tox screen. Dr. Hendrickson knows this patient well, and has reviewed the results. She will follow up with him next month." He refilled the Oxycontin.

26. On or about March 15, 2011, Dr. Hendrickson saw B.B. She reported 7/10 pain. Under treatment plan, the note stated "The patient states that she eats poppy seeds on a daily basis and this is a possible reason for possible positive MS on tox screen." Dr. Hendrickson refilled the Soma, Oxycontin, and Norco.

27. In the Spring of 2011, B.B. continued to be seen by Physician Assistants who refilled the Oxycontin and instructed her to continue with the Norco and Soma. On or about May 20, 2011, B.B.'s toxicology results showed negative for metabolites of Soma, and Norco, and negative for hydromorphone, but positive for oxycodone and oxymorphone.

28. On or about June 8, 2011, B.B. was seen by a Physician Assistant, reporting an 8/10 pain level. The note stated B.B. was taking Soma and Norco very infrequently which explained last toxicology results. The Oxycontin, Norco and Soma were refilled. Dr. Hendrickson co-signed the note on or about June 13, 2011. B.B. was seen again at H&H in July of 2011, with Oxycontin, Norco, and Soma refilled. On or about July 15, 2011, B.B. called to schedule an earlier appointment because she intended to travel out of state. The Medical Assistant explained that medications cannot be refilled earlier than scheduled and that prescriptions will state that they are not to be filled until the next scheduled date. B.B. stated she was not attempting to obtain an early refill. On or about July 25, 2011, B.B. was seen and reported 9/10 pain. The provider noted that she takes her medications as prescribed without side effects and stated "she was given one advanced prescription." The provider did not sign the note, but it is co-signed by Dr. Hendrickson. At this appointment B.B.'s blood pressure was 159/93, and her pulse was 71.

29. On or about August 31, 2011, B.B. returned and saw a Physician Assistant. She reported she had a myocardial infarction on August 8, 2011 and was hospitalized for a week for an angioplasty. She reported 6/10 pain. In addition to the template paragraphs regarding informed consent and activity goal, the treatment notes indicated that "the medications were reviewed and renewed as before, no changed were made. The patient feels they help to maintain a more active lifestyle, including activities of daily living, with less pain. There is no adverse effects reported today." Exercise and stretching were recommended.

30. On or about September 28, 2011, B.B.'s medications were refilled. On or about October 26, 2011, B.B. reported that she was admitted to U.C. Davis for congestive heart failure approximately 2 weeks ago, and that she is being managed with medications and will call with an updated medication list. Oxycontin was refilled.

31. B.B. appeared for another refill of Oxycontin and Norco on or about November 22, 2011, and December 20, 2011. At the end of 2011, the diagnosis of degenerative disc disease was replaced with idiopathic scoliosis, although there was no corresponding supporting documentation or history and physical. The post laminectomy syndrome diagnosis remained.

On or about January 18, 2012, the medication list stated that the Soma was discontinued, although it is not referenced in the notes of any of the previous several appointments. Also at the January 2012 appointment, B.B. reported 10/10 pain and was tearful regarding her constant pain. She stated she has enough Norco for the month, but the Oxycontin was refilled. She reported new hip pain, and was recommended to raise that with her primary care physician.

32. On or about February 21, 2012, B.B. continued to report increased pain. Her medications were refilled. There is an updated opioid consent form signed by B.B. in the record, dated February 21, 2012. On or about March 20, 2012, B.B. reported a 9/10 pain level and was again started on Neurontin. She was scheduled for a random toxicology screen. The toxicology screening was positive for oxycodone but negative for opiates. It was sent for confirmation which was positive for Oxycodone and Oxymorphone only.

33. On or about April 17, 2012, B.B. reported 8/10 pain and stated that she was unable to tolerate Neurontin and stopped it after four or five days. The Oxycontin was refilled, and

alternative pain management strategies such as mindfulness and relaxation techniques were reportedly discussed. On or about May 18, 2012, B.B. reported a pain level of 9/10, and the note stated that she was oriented with no obvious signs of CNS depression. The provider indicated that she had not had nerve blocks attempted for a long time and did not recall how successful they were in the past, so it would be appropriate to try them again. Her Oxycontin was refilled. At this point, B.B. had been on the same Oxycontin dose of 160 mg, four times per day for years. She reported that she was scheduled for a rectal prolapse repair in two weeks. On or about June 19, 2010, Dr. Hendrickson performed a nerve block with steroid injection under fluoroscopy and conscious sedation.

34. On or about July 23, 2012, B.B. saw Respondent for the first time at H&H. On or about July 23, 2012, B.B. reported having a prolapse repair with partial colectomy on July 12, 2012. Although there was a template history and physical, Respondent did not document a comprehensive history with justification for continuing the treatment plan specific to B.B.'s status and changed condition. Respondent refilled the Oxycontin. Dr. Hendrickson indicated that he supervised Respondent during her care of B.B. and approved her treatment from or about July 23, 2012, up through and including her discharge from the practice on or about May 7, 2014. Respondent has a Delegation of Services Agreement (DSA), with Dr. Hendrickson, listing him and Dr. B.K.H. as physician supervisors for her. The DSA does not contain specific controlled substances or a formulary for controlled substances to be relayed as drug orders under Dr. Hendrickson's supervision. Respondent acknowledged that H&H has no written formulary of controlled substances that Physician Assistants can relay orders for in the practice.

35. On or about August 20, 2012, Respondent refilled the Oxycontin, and Norco. B.B. reported a pain level of 9/10. B.B. reported that she could not tolerate Neurontin, so Respondent prescribed Lyrica for neuropathic pain.

36. A Medical Assistant entered a note indicating that a toxicology screen ordered at the August appointment was positive for opiates and Oxycontin and that B.B. was prescribed Norco, but further stated that there was no need for a confirmatory analysis. On September 19,

2012 B.B. again saw Respondent, reporting 8/10 pain. B.B. stated she had difficulty with the Lyrica but will continue taking it. Lyrica and Oxycontin were refilled.

37. On or about October 17, 2012, Respondent refilled Oxycontin and prescribed a Lidoderm patch. B.B.'s weight dropped to 101 pounds, and she reported 9/10 pain. She further stated that she discontinued the Lyrica on her own. Her blood pressure was recorded as high. Respondent continued to refill the Oxycontin 160 mg four times per day as it had remained for several years.

38. On or about November 13, 2012, the medical software changed, but the notes continued to contain the two template paragraphs stating that the patient is stable on current medications, with increased function and that all benefits and risks of medication have been discussed and understood. These chart notes are not co-signed by Dr. Hendrickson. B.B.'s Oxycontin prescriptions continued to be refilled at same level each month, as well as Norco prescriptions, with pain levels usually reported at 8/10 or 9/10. Actual prescriptions to B.B. from H&H, however, were often issued in much higher numbers of pills than she was instructed to take. On or about December 19, 2012, B.B. reported pelvic pain, and Respondent recommended that she follow up with her primary care physician. These similarly template chart notes with similar prescription orders continued during in or around January and February of 2013. In or about February 2013, B.B. told Respondent that she had stopped the Lidioderm patches. B.B. also reported having frequent and urgent bowel movements affecting her activity level and depression.

39. On or about March 27, 2013, B.B. again reported her pain level at 9/10, and stated that the frequent and urgent bowel movements continued. She stated she had a spinal cord stimulator that did not help with the pelvic pain, which she thought stopped working following straining after a bowel movement several years ago.

40. On or about April 25, 2013, the formatting of the medical records changed again. From this point on, Respondent reported that B.B. had never smoked, in contradiction to her initial history and physical at H&H, which reported a 25-year smoking history. On or about April 25, 2013, B.B. reported a pain level of 9/10, and stated that she fell and hit her head a glass table a

week earlier and had reduced hearing and vision. Respondent told B.B. to report to an Emergency Room or urgent care immediately as she may have suffered a subdural hematoma. The note still contained the template paragraphs that the medication prescribed allows greater function than without it, and that all risks of medications were explained and understood. Respondent refilled the Oxycontin and Norco. The instructions in the chart notes to B.B. are that she should take Oxycontin both around the clock as needed.

41. On or about May 30, 2013, B.B. reported a pain level of 9/10. Respondent listed diagnoses of post laminectomy syndrome, and periostitis without osteomyelitis, and pain in joint involving pelvic region and thigh. There is no specific history and physical documentation supporting the changed diagnosis. B.B.'s blood pressure is recorded as 167/87, and is not addressed further in the note. Respondent refilled the Norco and Oxycontin. B.B. reported that she had an MRI to rule out a hematoma following her fall and it was negative. Respondent ordered an x-ray of her hip.

42. On or about June 27, 2013, B.B. reported 8/10 pain and the Oxycontin and Norco were refilled. Respondent recommended a referral to an orthopedist for the hip, but B.B. declined it at that time. On or about July 24, 2013, the Oxycontin was refilled. B.B, reported that her primary care physician is following up with her for a possible diagnosis of rheumatoid arthritis. On August 28, 2013, B.B. reported 10/10 pain and her Oxycontin and Norco were refilled. A toxicology screen was ordered.

43. On or about September 28, 2013, B.B.'s pain was recorded at 10/10, and another toxicology was ordered. Respondent charted that B.B. experienced occasional somnolence from the medications, and that she did not drive with CNS depression. The Oxycontin was refilled. There are no toxicology reports in the file that relate to any toxicology screens Respondent ordered, and no references to the screening or reports in any of the medical records she signed.

44. On or about November 27, 2013, B.B. presented with 9/10 pain and reported that she would be seen at U.C. Davis for treatment of gallbladder stones and had an endoscopy scheduled. The Oxycontin and Norco were refilled. On January 17, 2014, the Oxycontin was refilled, and the notes continue to remain similar.

45. On or about February 14, 2014, B.B. reported memory loss issues and stated that she would follow up with her primary care physician. She further stated that she would have an endoscopic gallbladder procedure performed later this month. B.B. again reported drowsiness and constipation from the medications. The medications were refilled with no change in the regimen.

46. B.B. had gallbladder surgery at U.C. Davis, and was discharged on or around February 26, 2014. She presented to the Emergency Department on or about February 27, 2014 for an apparent overdose of Oxycontin causing low blood pressure. She was admitted due to "altered mental status," and to rule out complications from her surgery. She was diagnosed with C-difficile and was treated with antibiotics for sepsis. She had a repeat gallbladder procedure at U.C. Davis at the beginning of March 2014. She was admitted to the hospital UC Davis and had another gallbladder surgery on or about March 7, 2014. During this hospitalization at U.C. Davis, there was a consultation note from the Pharmacy Pain Management specialist, dated on or about March 3, 2014 stating that B.B. was a complex patient with acute pain secondary to cholangitis. The consultation note further stated that although B.B.'s regimen for opioid medications to be taken at home, by mouth, each 24 hours was equivalent to 960 mg morphine per day, "currently, patient's 24 hour opioid requirement equivalent to approximately 350 mg po morphine per day. Questionable adherence to home regimen due to negative urine drug screen and current sensitivity to hydromorphone IV. Patient may benefit from adjustment of analgesic regimen." B.B. was released from UC Davis on or about March 14, 2014.

47. On or about March 17, 2014, B.B. presented at the Emergency Room at Mercy Hospital of Folsom. She was diagnosed with hypotension most likely secondary to excessive narcotic pain/medication. The discharge summary noted that B.B. had been discharged from U.C Davis earlier that week following gallbladder surgery and a post-surgical infection. At that point, she had reported taking 160 mg of Oxycontin four times per day and U.C. Davis reduced her to 80 mg twice per day. In an assessment and plan, it was noted that B.B. was dehydrated. The discharging physician concluded that the use of opioids probably contributed to the hypotension B.B. experienced and ordered physical therapy. He decreased the prescribed opioid dose and referred B.B. to follow up with her pain management specialist.

48. On or about March 19, 2014, B.B. had an appointment at H&H with Respondent. Respondent noted that B.B reported 10/10 pain and, "was in Mercy Folsom recently. We have received a discharge summary." B.B. stated the pain has been intolerable since her gallbladder surgery. There is a conflicting, lengthy note by Respondent. She states that B.B. has been stable on high dose Oxycontin for the previous 10 years. She further indicated that B.B.'s acute or surgical pain will be difficult to manage, and addressed issues of opioid-induced hyperalagesia. Respondent noted that Mercy Folsom had reduced the Oxycontin dose to 80 mg three times per day, but B.B.'s pain increased, so she will raise it, and make a slower titration schedule for the Oxycontin. Respondent further referred B.B. for psychological counseling. The prescribed amount of medication did not correspond to her instructions to B.B.

49. On or about March 26, 2014, B.B.'s husband left a telephone message stating that B.B. had been experiencing cognitive impairment and mental confusion for months. He indicated that she stops actions in mid-motion. He was concerned that the Oxycontin withdrawal may be causing the symptoms. Respondent documented having informed him that cognitive impairment is not a withdrawal symptom and that B.B. should follow up with her primary care physician for an evaluation of possible mental status changes if necessary. She further directed him to continue with the titration schedule for reducing the Oxycontin, and return in one week.

50. On or about April 2, 2014, Respondent noted that she would maintain B.B. on the same dose and not continue further titration because B.B. complained of pain. On or about April 16, 2014, Respondent's notes indicated that B.B. said she managed to decrease her dose of Oxycontin to 80 mg Q8H for the last week and she wanted to continue this because it is helping her to have improved attention. It further indicated that B.B. had some 40 mg pills left over, so Respondent directed her to continue her current regimen and that she may take the extra 40 mg if the pain became too severe and to follow up in two weeks. Again the medications directions were not clear and did not correspond to the prescribed amounts. Respondent noted that B.B. would be having ultrasounds on her lower extremities to rule out venous thrombosis and that she had begun counseling with the psychologist.

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51. On or about April 30, 2014, B.B. reported 10/10 pain and denied weakness or fatigue, and was "alert and awake" and had "good mental clarity." The chart note also indicated, that B.B. fell asleep twice while talking to the Medical Assistant, and had to catch herself before falling out of the wheelchair while speaking to Respondent. Further, Respondent reported that B.B. lost attention several times while speaking to her. B.B.'s family reported that she had been having excessive sleepiness and had been falling out of her wheelchair recently, hitting her head several times. As the lengthy note continued, Respondent wrote that the family was concerned B.B. may not be taking the medications as prescribed and taking more than what she was instructed. B.B. stated that she was taking the medications as prescribed. Respondent noted that she told the family that if they believe she is not taking the medications appropriately they would have to discontinue prescribing medications because this can be very dangerous. B.B.'s husband then reported that he found a bottle of 100 tablets of 80 mg Oxycontin, unused. Respondent noted that B.B. was due for urine screen, but did not have to urinate, and so she would do blood work instead. The notes also stated that Respondent recommended B.B. continue with further titration of the Oxycontin to 60 mg three times per day. But, there is no indication that blood work or medication change was done. Instead, there was another statement that Respondent would "hold off on prescribing medication." Respondent stated that she was concerned about the drowsiness and referred B.B. to the Emergency Room immediately. The note also contained the template paragraphs that the benefits and risks of opioid medication have been explained and the patient agrees to proceed with medication management, and that the patient understands and all questions have been answered, as well as the paragraph that the goal of medication is to improve function.

52. On or about April 30, 2014, after her appointment with Respondent, B.B. presented to the Mercy Folsom Emergency Room. There is a complete history and physical performed stating as follows: "History of MI, Chronic back pain on high dose Oxycontin, recent dx of bilateral lower extremity DVT, referred to ER by pain specialist for frequent falls and altered mental status. Fell yesterday and hit her head. 20-years of pack per day smoking, quit 10 years ago. Limited social alcohol consumption HR 50, respiratory rate 17, BP 126/76 slightly bradycardiac. Assessment and plan: altered mental status secondary to narcotic overdose with dehydration."

Among other orders, there was a request for pain management consult. She was maintained in hospital and checked to rule out CVA. She was reported to be unsure of medications she was taking, very drowsy, groggy and deconditioned, requiring a walker for ambulation.

53. B.B. was admitted to Mercy Hospital from on or about April 30, 2014 through May 1, 2014. She was diagnosed with altered mental status and frequent falls mostly likely secondary to medication over use. A CT of the head was negative. The Emergency Room reduced B.B.'s Oxycontin from 80 to 40 mg three times per day, and she was seen by physical therapy.

54. On or about May 2, 2014, B.B.'s husband left a telephone message for Respondent at H&H. He stated that B.B. was discharged from Mercy Folsom and he would like to speak to Respondent because Mercy Hospital recommended a medication consultation. He stated it was an emergency and wanted to speak to her today. A Medical Assistant explained that Respondent was busy and may not respond this morning. B.B.'s husband left another message that afternoon, and the Medical Assistant instructed the husband that based on determination made by the physician with Mercy Folsom H&H's Medical Director will have to review B.B.'s medication regimen. The husband explained that B.B. was currently in extreme pain and asked for a prescription to make her more comfortable while waiting for an appointment.

55. The final chart note on or about May 7, 2014, reflected an office visit with Respondent at H&H. The note stated that B.B. reported having lost her Norco bottle and was currently not taking the medication. Respondent stated that she had informed B.B. that she could not continue to prescribe opioid medications "as was Dr. Hendrickson's decision because [she] experienced an adverse event while taking Oxycontin and it is unclear if she was taking the medication as prescribed." She further stated that she discussed a trial of Duragesic patches for pain. The note then indicated that when Respondent asked B.B. if she had any further questions, "the patient-provider relationship was breeched as the husband expressed his displeasure about the care [she] had received with our clinic for the past 10 years. Due to the breech in the provider-patient relationship I cannot prescribe further medications and provided the patient with a titration schedule for her Oxycontin using the remaining tablets." She stated that she provided her with a list of other pain management providers in the area.

56. During her interview with the Board, Ms. Respondent explained that "breech" referred to in the record was that B.B.'s husband lunged at her violently, causing her to fear for her safety. She stated that she conferred with the Office Manager, who is a Medical Assistant, and they developed the following titration schedule, which they provided to B.B. with a list of other providers in the area:

"Day 1-5 take 1 tablet by mouth once each day

Day 6-8 take 1 tablet every other day

Day 9 off medication"

57. Respondent further stated that a Durable Power of Attorney for Health Care Decisions was put in place in or around 2002, naming B.B.'s husband as the Power of Attorney although there was no evidence of lack of capacity at that time and she attended most appointments without him and made her own medical decisions. However, Respondent stated that in May of 2014, B.B. lacked capacity and since her husband was the Power of Attorney for B.B., and had been violent at the clinic, she could no longer see him, and consequently could not see B.B. either. The Office Manager referred B.B. to the H&H Detoxification Unit, which was located on the same premises as the pain management clinic.

58. B.B.'s primary care physician and psychologist attempted to assist her following her discharge from H&H by finding alternate pain management care. Calls from B.B. and her psychologist to H&H requesting additional care were not returned.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

59. Respondent has subjected her license to disciplinary action under sections 3527 and 2234, subdivision (b), for unprofessional conduct in that she was grossly negligent. The circumstances are as follows:

60. Paragraphs 12 through 58 above are repeated here as if fully set forth.

61. Respondent was grossly negligent in her care and treatment of Patient B.B. for her acts including, but not limited to, the following:

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a. Failing to conduct and document a detailed history and examination of B.B. upon assuming her care;

b. Failing to appropriately address, document and alter treatment plan and medications over the course of treatment and in response to reports of adverse effects from medications;

c. Failing to conduct periodic reassessment and documentation of the medical indications for continuing or altering medications;

d. Failing to conduct appropriate medical management of comorbidities, or to refer for medical treatment of physical symptoms of underlying medical conditions and to coordinate care with other medical providers;

e. Providing excessive medications to B.B.;

f. Providing inconsistent and confusing directions to B.B. regarding her use of the medications being prescribed to her and providing prescriptions that contradicted the instructions to the patient on how to take the medications;

g. Attempting to treat a complex, chronic pain patient without adequate supervision from her supervising physician;

h. Failing to obtain meaningful informed consent for the types and changes in the medication provided to B.B.;

i. Failing to obtain consultations when appropriate and for addiction and dependence in response to signs of possible medication misuse;

j. Failing to comply with DEA and drug manufacturer guidelines for prescribing, or to document a reasonable basis to depart from these guidelines; and

k. Inappropriately terminating B.B. from care with insufficient alternative access to care and follow up.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

62. Respondent has subjected her license to disciplinary action under sections 3527 and 2234, subdivision (c), for unprofessional conduct in that she engaged in repeated negligent acts as follows:

63. Paragraphs 12 through 58 above are repeated here as if fully set forth.

64. Respondent was repeatedly negligent in her care and treatment of Patient B.B. for her acts including, but not limited to, the following:

a. Failing to conduct and document a detailed history and examination of B.B. upon assuming her care;

b. Failing to appropriately address, document and alter treatment plan and medications over the course of treatment and in response to reports of adverse effects from medications;

c. Failing to conduct periodic reassessment and documentation of the medical indications for continuing or altering medications;

d. Failing to conduct appropriate medical management of comorbidities, or to refer for medical treatment of physical symptoms of underlying medical conditions and to coordinate care with other medical providers;

e. Providing excessive medications to B.B.;

f. Providing inconsistent and confusing directions to B.B. regarding her use of the medications being prescribed to her and providing prescriptions that contradicted the instructions to the patient on how to take the medications;

g. Attempting to treat a complex, chronic pain patient without adequate supervision from her supervising physician;

h. Failing to obtain meaningful informed consent for the types and changes in the medication provided to B.B.;

i. Failing to obtain consultations when appropriate and for addiction and dependence in response to signs of possible medication misuse;

j. Failing to comply with DEA and drug manufacturer guidelines for prescribing, or to document a reasonable basis to depart from these guidelines; and

k. Inappropriately terminating B.B. from care with insufficient alternative access to care and follow up.

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THIRD CAUSE FOR DISCIPLINE
(Failing to Establish Written Guidelines for Physician Assistant Supervision)

65. Respondent has subjected her license to disciplinary action under sections 3527, 2234, subdivision (a), and sections 3503.1 and 3502, for unprofessional conduct in that she failed to establish written guidelines including drug formularies for her supervision in providing controlled substances to B.B. as a physician assistant.

66. Paragraphs 12 through 58 above are repeated here as if fully set forth.

67. As set forth in paragraphs 12-58, Respondent prescribed and altered medications for B.B., a complex pain patient, without written guidelines or medication formularies to guide her practice, and without obtaining prior authorizations from a supervising physician.

68. Respondent's conduct as described above constitutes unprofessional conduct in violation of sections 3527, 2234, subdivision (a), 3502.1, and 3502, subdivision (b) of the Code, and thereby provides cause for discipline to Respondent's physician assistant certificate.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

69. Respondent has subjected her license to disciplinary action under sections 3527, 2234 and 2266 for unprofessional conduct in that she failed to maintain adequate and accurate records relating to the provision of services to patients.

70. Paragraphs 12 through 58 above are repeated here as if fully set forth.

71. As set forth above, Respondent failed to maintain adequate and accurate records of the care provided to B.B., which constitutes unprofessional conduct in violation of sections 3527, 2234 and 2266 of the Code, and thereby provides cause for discipline to Respondent's Physician Assistant certificate.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board issue a decision:

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1. Revoking or suspending Physician Assistant License No. PA 22290, issued to Respondent Tira Rene Palfini, P.A.

2. Ordering Respondent Tira Rene Palfini, P.A. to pay the Physician Assistant Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: March 17

MAUREEN L. FORSYTH
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

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1. Revoking or suspending Physician Assistant License No. PA 22290, issued to Respondent Tira Rene Palfini, P.A.

2. Ordering Respondent Tira Rene Palfini, P.A. to pay the Physician Assistant Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: March 15, 2017

MAUREEN L. FORSYTH
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

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